Original Article

Health Care Utilization, Barriers to Care among Lesbian, Gay, Bisexual and Transgender Persons in Turkey

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Abstract

Lesbian, gay, bisexual and transgender people (LGBT) are a population group that has largely been ignored in terms of their primary healthcare needs. This descriptive study was conducted to explore primary health care utilization and barriers to care among LGBT persons in Turkey. The study sample consisted of 100 members of LGBT associations and university communities. It was determined that LGBT individuals utilized Family Health Centers at a very limited level. The perceived barriers of the participants regarding the experience of discrimination and the insensitivity of doctors towards their special health needs vary according to their sexual orientations.

Key words: LGBT, discrimination, sexual orientation, primary health care

Introduction

Despite the increasing social tolerance to LGBT individuals within the past thirty years, discrimination against LGBT individuals still persists in today's society and health care institutions (Irwin 2007; Lim & Levitt 2011). Health is an integral part of the right to life, the most fundamental human right. In this context, access to the right to health refers to an individuals' utilizing the health care services regardless of their ethnic origin, religion, language, gender, sexual orientation, ability and age (Chapman et al. 2012; Anon 2012). Many research indicate that LGBT individuals are not only subject to (Dunjić-Kostić et al. 2012) mental disorders such as depression-related suicide attempts and substance use (Cochran et al. 2007; King et al. 2008; Cochran & Mays 2009), but also physical disorders such as sexually transmitted diseases, cancer and cardiovascular diseases (Ridner et al. 2006; Dahan et al. 2007).

LGBT individuals face financial, structural, personal and cultural barriers as they attempt to access competent, sensitive health care services (Lim & Levitt 2011; Tuzer 2003). The previously conducted international research revealed that LGBT individuals experienced negative attitudes at a rate of 31-89% because of their sexual orientation (Irwin 2007). LGBT individuals express that they encounter negative and hostile reactions from health professionals when their sexual orientation is revealed (McNair & Medland 2002; Gorton 2006; Henrici 2007). Furthermore, such negative reactions or fear of such reactions prevent LGBT individuals from receiving health services when they are in need (Pettinato 2012). Such obstructions prevent LGBT individuals from receiving the health screening and protective services they need and cause delays in providing them with the care they need in acute cases (Dean et al. 2000; Jenner 2010). Negative attitudes against LGBT individuals are common in most societies (Irwin 2007; Gorton 2006) which is also valid for the Turkish society (Sakalli 2002; Duyan & Duyan 2005; Gelbal & Duyan 2006; Sakallı Ugurlu 2006).

In Turkey, the concept of homosexuality started to attract the attention of society in mid 1980s. Since that date, prejudices, pressure and negative

attitudes against homosexuals have continues despite significant changes occurring, especially, in big cities in terms of rights and ways of perception (Duyan & Gelbal 2004; Anon 2012).
In terms of gender equality, health is one of the fields in which Turkey has committed to providing the necessary precaution, protection and improvement according to the documents of the conventions she unreservedly accepted as a party (Anon 2012). In parallel with these social developments, scientific research, mainly in social sciences, is being conducted in order to identify the problems of LGBT individuals (Sakalli 2002; Aksoy 2003; Basaran 2003; Duyan & Duyan 2005; Gelbal & Duyan 2006; Sakallı Ugurlu 2006). However, in the field of medicine, a very limited number of studies have been conducted to determine the attitudes of medicine and nursing students towards LGBT individuals in recent years (Cabuk 2010; Celik & Hotun Sahin 2004; Bostanci Dastan 2015). In the review of the literature produced in our country, any research on LGBT individuals' condition of using health services was not observed except for a few monitoring and workshop reports which evaluate this condition in terms of the social security system.

This research was conducted to determine LGBT individuals' condition of utilizing the primary health care and the barriers obstructing this process.

Background

Sexual orientation expresses how people perceive themselves, which sex they are interested in and their erotic object of choice (Tuzer 2003; Celik & Hotun Sahin 2004). In this sense, sexual orientation is independent of an individual's gender identity and it can exist in accordance with or opposite an individual's gender identity. A person's sexual orientation can be heterosexual, homosexual or bisexual (Tuzer 2003; Celik & Hotun Sahin 2004). The LGBT abbreviation is used as an umbrella term. LGBT individuals experience unprecedented health inequalities. Although the health needs of this community are grouped in the same category, each letter represents a separate population with their particular problems (Anon n.d.). In Turkey, the concept of homosexuality is mostly considered synonymous with the concept of "gay". The concepts of gay, lesbian, bisexual and transsexual which encompass homosexuality are not taken into account much, and homosexuality is mostly considered to be encompassing being gay (Duyan & Gelbal 2004).

Homosexuality was declassified as a mental illness by the American Psychiatric Association in 1973; and removed off the list of "the International Classification of Diseases" by World Health Organization (WHO) in 1992. In accordance with scientific views, researchers shared the ideas which started the perception of homosexuality as normal (Irwin 2007; Anon 2012; Campo-Arias et al. 2010; Ard & Makadon 2012; Jenner 2010).

Although it is a scientifically accepted fact that homosexuality is not a disease, homosexuals are still being stigmatized as "sick", "pervert" or "abnormal" and forced to become heterosexual (Ard & Makadon 2012; Duyan & Gelbal 2004). Today, homophobia is a term used to describe the negative, fearful or hateful feelings, attitudes and/or behaviors of heterosexual people towards those with different sexual orientations such as bisexuals and gays (Celik & Hotun Sahin 2004; Smith 2004). Discriminatory behaviors caused by sexual orientation are based on homophobic beliefs and prejudices (Yetkin 2016). Homophobia is supported by cultural norms; manifesting itself through anxiety, fear, disgust, anger, hatred, discomfort, dislike and angry behavior against homosexuals (Celik & Hotun Sahin 2004; Selek 2001).

Homophobic reactions against LGBT individuals not only affect their economy, social security and personal relationships but also their use of health services. People who identify as LGBT are a population group that has largely been ignored in terms of their primary healthcare needs beyond the healthcare issues associated with HIV, AIDS and other sexually transmitted diseases. Lack of awareness among healthcare professionals about the primary healthcare needs of this population group has the potential to result in giving ill- or uninformed advice, and consequently missed opportunities for the health promotion and education. It appears that some LGBT people avoid disclosing their sexuality to health care providers for fear of discrimination or negative responses (Irwin 2007; McNair et al. 2001). A provider's lack of understanding about household composition may result in poor adherence to recommended therapies and lead to other misunderstandings. Thus, disclosure of sexual identity in the healthcare setting is essential if clinicians are to meet the health needs of LGBT

communities appropriately (Neville & Henrickson 2006).

In Turkey, primary care services consists of two main actors, the family health centers and public health centers, which interact with the secondary and tertiary services. The population already registered with the family health center (FHC) is allocated according to their geographic location to a FHC. Each FHC is staffed with one family doctor (a medical practitioner, who has had introductory training in family practice and is expected further to participate in a 1-year distance learning course in family practice) and one family health staff worker (usually a nurse or midwife) (Gunes & Yaman 2008). The family doctor deals with the individuals within their family and community context and provides preventive health care and treatment together and deals with the biological, psychological and social aspects of the indiviudals under his/her responsibility. They are chosen by the individuals themselves (Anon 2006). Family doctor and family health staff worker provide preventive and curative services. Immunization of different risk groups (especially childhood), screening pregnant women and newborns, home visits are a part of daily routine.

Methods

Design

This research is a descriptive study conducted to determine primary health care utilization and barriers to care among lesbian, gay, bisexual and transgender (LGBT) persons. The sample of the research consisted of 100 individuals who were members of Facebook groups of LGBT associations and university communities who volunteered to participate in the research.

Data Collection

For data collection, a questionnaire developed by researchers in line with the literature (Dean et al. 2000; Cabuk 2010; Ard & Makadon 2012; Neville & Henrickson 2006) was used. The questionnaire is comprised of three parts; the first part including questions on the socio-demographic characteristics of LGBT individuals, the second part including questions on the health conditions and application of LGBT individuals to health institutions, and the third part including questions on LGBT individuals' experiences of utilizing the health care services offered at Family Health Centers and the barriers obstructing this process. The questionnaire was available both electronically and in hard copy data were collected between April and May 2013. Electronic sampling is becoming both more popular and more accepted in research with so-called "hidden" population (Neville & Henrickson 2006; Riggle et al. 2005). Anonymity was ensured by separating email addresses from completed questionnaires on return and by ensuring that no personal identifiers were evident on either electronic or hard copies.

Data Analysis

Data were imported from the website or hand-entered into an SPSS 16.0 (SPSS Inc. 1989–1999) spreadsheet for statistical analysis, including chi-square tests. The data were screened for duplications, data entry accuracy and missing values. A statistical significance level of 0.05 was chosen.

Results

Socio-demographic Characteristics of LGBT Individuals

Table 1 summarizes demographic/personal characteristics of the LGBT population. The mean age of the LGBT individuals is 24,37±4,05 and 80% have undergraduate or graduate degrees. Of the LGBT individuals, 72% stated that they had a job which would be a source of income while 9% stated that they did not have any health insurance. Of the LGBT individuals, 60% stated that their sex was male at birth. When the participants were asked how they defined their sexual orientation, 63.0% stated they were homosexual, 27.0% were bisexual and 10% were heterosexual.

LGBT Individuals' Condition of Utilizing Family Health Centers

Of the LGBT individuals, 22% have at least one chronic disease. When the health institution preferences of LGBT individuals are analyzed, it is seen that 17.5% prefer Family Health Centers (FHC), 25% prefer State Hospitals, 30% prefer University Hospitals and 27.5% prefer Private Health Institutions (Table 2).

When the LGBT individuals were posed the question; "Would you apply to a FHC whenever you have a health problem?" 31% responded positively. However, the question; "Would you tell your sexual orientation to your family doctor/nurse?" received the answer "yes" from only 2% of the LGBT individuals. When they were asked about the reasons why they applied to

a FHC in the past three months; 36.8% stated that their reason was prescription while 26.5% stated that they applied to be examined. The rate of those who applied for preventive care services (immunization, contraceptive supplies, consultation) was 14,9%. Of the LGBT individuals, 42,0% stated that they preferred FHCs because of their convenience (Table 2).

Table 1. Sociademographic Characteristics of Participants

Socio Demographic Characteristics	n	%
Age groups		
18 to 22	35	35.0
23 to 27	44	44,0
28 and older	21	21.0
Gender at Birth		
Female	40	40.0
Male	60	60.0
Sexual Orientation		
Homosexual	63	63.0
Heterosexual	10	10.0
Bisexual	27	27.0
Educational Status		
High School Graduate	20	20.0
Bachelor's Degree and above	80	80.0
Working Status		
Yes	72	72.0
No	28	28.0
Working Style		
Part-time	29	29.0
Full time	44	44.0
Health Insurance		
State Health Insurance	84	84.0
Private Health Insurance	7	7.0
No Health Insurance	9	9.0
Income and Expenditure Statement		
Income is less than expenditure.	29	29.0
Income and expenditure are equal.	44	44.0
Income is more than expenditure.	27	27.0
TOTAL	**100**	**100.0**

Table 2. Utilization of lesbian, gay, bisexual and transgender Individuals of Family Health Center (FHC) Services

	n	%
Do you apply to the FHC every time you need?		
Yes	31	31.0
No	69	69.0
Why did you apply to the FHC center in last three months?*		
For medication request Physician/Nurse	32	36.8
To get examined	23	26.5
To consult to the Physician/Nurse	4	4.6
Be vaccinated	4	4,6
To get condom	3	3.4
To get oral contraceptive pill	2	2.3
To companion to someone	3	3.4
Emergency situations	6	6.9
Medical dressing / Injection	6	6.9
Other reasons	4	4.6
Do you tell your sexual orientation to your Family Physician/Nurse?		
Yes	2	2.0
"Yes" in necessary conditions	31	31.0
No	67	67.0
TOTAL	**100**	**100.0**

** multiple responses possible*

Table 3. Barriers for utilizing of Family Health Center (FHC) Services of lesbian, gay, bisexual and transgender Individuals by sexual orientation

		Sexual Orientation*			
Barriers for utilizing of FHC Services		Homosexual (n=63) %	Heterosexual (n=10)%	Bisexual (n=27)%	X^2, p
The fear of rejection	Yes	36.5	60.0	33.3	2.36, 0.30
	No	63.5	40.0	66.7	
Homophobic reactions	Yes	30.2	60.0	25.9	4,16, 0.12
	No	69.8	40.0	74.1	
Be exposed to discrimination	Yes	22.2	60.0	29.6	6.16, 0.04*
	No	77.8	40.0	70.4	
Insensitivity of the physicians to the private health care (PHC)	Yes	19.0	50.0	40.7	7.08, 0.02*
	No	81.0	50.0	59.3	

needs					
Inadequate knowledge of the physicians about sexual orientation	Yes	28.6	50.0	29.6	1.89, 0.39
	No	71.4	50.0	70.4	
Insensitivity of the nurses to the PHC needs	Yes	44.4	80.0	48.1	4.38, 0.11
	No	55.6	20.0	51.9	
Inadequate knowledge of the nurses about sexual orientation	Yes	27.0	40.0	25.9	0.80, 0.66
	No	73.0	60.0	74.1	

p <0.05

Barriers to LGBT Individuals' Utilizing Family Health Centers

When the sexual orientation of LGBT individuals and the factors influencing their condition of using FHCs are compared; 63.5% of those who identified as homosexuals, 40.0% of heterosexuals and 66.7% of bisexuals expressed that they did not apply to a FHC whenever they needed because of the fear of rejection. Similarly, 69.8% of those who identified as homosexuals, 40.0% of heterosexuals and 74.1% of bisexuals expressed that they did not apply to a FHC whenever they needed because of homophobic reactions. However, the sexual orientations of the individuals did cause a statistically significant difference in fear of rejection (X^2=2.363, p=0.307) and perceiving homophobic reactions as a barrier (X^2=4.159, p=0.125) when applying to a FHC. Nevertheless, the perception of the research group regarding discrimination in applying to a FHC demonstrated differences according to their sexual orientations (X^2=6.158, p=0.046) (Table 3).

The perception of the individuals included within the scope of the research regarding the insensitivity of doctors to their special health needs when applying to a FHC varied according to their sexual orientation (X^2=7.079, p=0.029). On the other hand, while 71.4% of the individuals who defined their sexual orientation as homosexual, 50.0% of heterosexuals and 70.4% of bisexuals considered doctors' insufficient knowledge on sexual orientation as a barrier, this condition did not cause a statistically significant difference (X^2=1.885, p=0.390). The sexual orientation of the LGBT individuals did not demonstrate a statistically significant difference (Table 3) in their perception regarding the insensitivity of doctors to their special health needs (X^2=4.377, p=0.112) and their insufficient knowledge on sexual orientation (X^2=0.804, p=0.669).

Discussion

This was a highly educated sample, with 80% of respondents having an undergraduate or postgraduate degree compared with 29.1% of the Turkish population in general (Anon 2013). Similar to our research sample group, in the study conducted by Neville and Henrickson (2006) in New Zealand, it was determined that 51.0% of the LGBT individuals had an undergraduate or postgraduate degree. The fact that the level of education in our sample group was at a higher rate might have been caused by the collection of data from LGBT associations and internet groups in Turkey. That is to say, the initiative to discuss gender identity through associations and the internet requires a higher awareness and education; thus, individuals with higher education might have participated in the research.

When the economic perception and working conditions of the LGBT individuals who have participated in the research were analyzed, it was determined that 72% had a job and 29% perceived their income to be less than their expenses. (Table 1). This result obtained in our research is supportive of the view in the literature that LGBT individuals earn less compared to heterosexuals despite their higher educational level in respect to the general population (Neville & Henrickson 2006; Anon n.d.). It was determined that 9% of our research group did not have any health insurance. In another study conducted in Turkey, 14,1% of LGBT individuals declared that they were not covered

by any health insurance (Yılmaz & Gocmen 2015).

People with LGBT populations display health-seeking behaviors that differ from the mainstream. They may either avoid mainstream health care or delay seeking health care (McNair et al. 2001). A great majority of the LGBT individuals in the research (89%) stated that they applied to a health institution when they encounter an illness (Table 2). When this result is compared to the results of studies conducted with heterosexuals in my country, the percentage of LGBT individuals' application to health institutions shows a similarity with those of the heterosexuals (Hıdıroglu et al. 2009). However, there are differences regarding the LGBT individuals' preference of the institutions in case of illness. Among the institutions preferred by LGBT individuals in case of illness, university hospitals are seen to take first place (30%) followed by private health institutions (27,5%) (Table 2). On the other hand, in many studies conducted with heterosexual individuals in our country, it is stated that the institutions individuals first apply to in case of illness are state hospitals (Hıdıroglu et al. 2009; NaCar et al. 2004). The reasons why LGBT individuals prefer big institutions like university hospitals and private health institutions, unlike heterosexuals, might be related with the fact that they are subjected to fewer cases of discrimination, exclusion etc., their needs (the protocols for gender change operations) are met by general hospitals and that health staff in such institutions come across more LGBT individuals resulting in a less homophobic profile (Dean et al. 2000).

When the LGBT individuals' condition of applying to a FHC for primary health care services was analyzed, it was seen that only 31% of the participants stated that they applied to a FHC whenever they needed (Table 2). It is thought that LGBT individuals' low rate of using family health centers might be caused by the family perception of these centers which prioritized services provided to pregnant women and infant/child health. Furthermore, some researchers emphasize that information requested in some registration documents used for the presentation of primary health care services rather address heterosexual families which may keep LGBT individuals away from these institutions (Dean et al. 2000; Neville & Henrickson 2006).

Under utilisation of health services has an obvious negative impact on the health care needs of LGBT people and their access to preventative measures such as screening programs for a number of health conditions (Irwin 2007). Similarly, the LGBT individuals who participated in our research use family health centers mostly for having a prescription, examination, dressing or injection. While none of the LGBT individuals participate in screening programs, it is seen that they benefit from preventive health services such as immunization and condom supply (Table 2).

Disclosing one's sexual orientation is a phenomenon that is unique to LGBT people. Heterosexual populations need not worry about disclosure, for heterosexuality is almost inevitably assumed (Neville & Henrickson 2006). It appears that some LGBT people avoid disclosing their sexuality to health care providers for fear of discrimination or negative responses (Irwin 2007; McNair et al. 2001). Similarly, our study found that more than half of the LGBT individuals (67%) who applied to a FHC did not tell their sexual orientation to health staff and that 31.0% told them when necessary.

Barriers to accessing health care, risk factors and specific health issues can relate to social determinants of sexuality and gender identity (McNair et al. 2001). Drawing on this fact, we compared the sexual orientation of the research group with their condition of using FHCs in our study. Several studies have highlighted the impact of homophobia and heterosexism on the health of LGBT people, the ability of LGBT people to access health care, and the quality of care they receive (Irwin 2007; Chapman et al. 2012; Gorton 2006; Henrici 2007; Dean et al. 2000; Neville & Henrickson 2006; Dorsen 2012). In parallel with the findings of the literature, our study also revealed that in spite of a statistically significant correlation, individuals who define their sexual orientation as homosexual and bisexual (69.8%-74.1%) consider homophobic reactions as a barrier to receiving primary health care services at high rates (Table 3).

Homophobia and heterosexism can be viewed as different aspects of the same phenomena: discrimination against LGBT people (Irwin 2007). LGBT people avoid the health care system because of past discriminatory experiences or expectations they will experience prejudice when they access primary health

services (Irwin 2007; McNair & Medland 2002; Henrici 2007). In our study, too, more than three quarters of the individuals who define their sexual orientation as bisexual and homosexual (70.4%-77.8%) state that they do not want to apply to a FHC whenever they need because of the fear of being discriminated ($p \leq 0.05$)(Table 3). In a letter Gorton (2006) wrote to the editor of the American Family Physician Journal, he stated that the major reason why 70% of transgender individuals delay receiving health care is the discriminatory attitudes of health staff (Gorton 2006). On the other hand, in a study conducted with LGBT individuals in Australia, 27% of the participants expressed that they experienced discrimination in medical treatment and the study also found that the rate of discrimination varied according to sexual orientation (Boch 2012). The difference between the two countries regarding the experience of discrimination might be caused by the fact that culturally sensitive approach towards LGBT might have started earlier in Australia (Irwin 2007) and the patriarchal structure of Turkey (Sakallı Ugurlu 2006).

Many LGBT persons have reported that their doctors are not sensitive to or knowledgeable about their particular health risks and needs, and do not disclose pertinent information about treatments or prevention (Dean et al. 2000; McNair et al. 2001). In support of this view, 81% of those who define their sexual orientation as homosexual identified the insensitivity of doctors towards their special health needs as a barrier to their application to a FHC ($p<0.05$). Nevertheless, although the poor knowledge of doctors specific to LGBT individuals were stated as a barrier in access to health care services (McNair et al. 2001; Cabuk 2010; Jenner 2010) this condition did not demonstrate a statistical significance in our study (Table 3).

Nurses spend more time interacting with patients than do other health professionals. Because of their unique responsibility for patient care, it is vital to ensure that nurses provide competent care for all patients (Boch 2012). Because of the poor knowledge of nurses regarding LGBT individuals and their negative attitudes, LGBT individuals experience difficulties in receiving sufficient health care and counseling (Rondahl et al. 2004; Neville & Henrickson 2008). In our study, too, half of those who defined their sexual orientation as homosexual and bisexual considered the insensitivity of nurses to their special health needs as a barrier to prefer FHC services. Similarly, the poor knowledge of nurses regarding sexual orientation was stated as a barrier to utilization of FHC services by more than half of the LGBT services (Table 3).

This study has certain limitations in terms of sample size and the characteristics of the sample. In traditional and closed societies like Turkey, sexuality and sexual preference are not issues that could be easily researched. Individuals cannot reveal their sexual orientations in every environment because of discrimination and homophobic reactions. Therefore, to reach the sample group, we preferred to use non-governmental organizations and Facebook, which is a social media platform, where they would express themselves more comfortably. The research group consisted of individuals who were active internet and social media users and who worked in organizations or institutions related with their sexual orientations. This condition resulted in a more limited participation of people with a high level of education.

Conclusion

The results of this study showed that LGBT individuals mostly preferred university and private health hospitals in meeting their health requirements while they applied to family health centers at lower rates. Nevertheless, LGBT individuals apply to family health centers mostly for medical treatments such as having a prescription or injection. It was determined that the sexual orientation of LGBT individuals affected their perceived barriers in application to FHCs under the headings of experiencing discrimination and the insensitivity of doctors to their special health needs.

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